Patient Information

Patient Name: _____ Preferred name: _____
Last First MI *How do you prefer we address you?*

☐Male ☐Female ☐Married ☐Single ☐Child Occupation: _____

Age: ____ Date of Birth: ____ / ____ / _____ Telephone #s (Home): _____
Month Day Year

Address: _____ (Cell): _____

E-Mail address: _____ (Work): _____ Ext ____

Hobbies/Interests: _____
OPTIONAL

⇨ ⇨ **Please Provide Your Health Information - - All Records Are Kept Confidential** ⇦ ⇦

Name of Physician: _____ Phone: _____

↳ Do we have your permission to consult with your physician? ☐Yes ☐No Clinic or Facility: _____

Whom may we notify in case of Emergency? Name: _____ Phone: _____

↳ Their Relationship to You : _____

- How would you describe your present health? (circle one): **Excellent Good Fair Poor Not sure**
- Are you now under the care of a physician? ☐Yes ☐No Date of last physical examination: _____
- Have you been a patient in a hospital, or under a doctor's care in the past two years? ☐Yes ☐No
  - ↳ If yes, please explain: _____
- Do you take any medicines or drugs? (*Include* aspirin, vitamins, antacids, herbals, hormones, caffeine) ☐Yes ☐No
  - ↳ If so, list here → ℞: _____
  - ↳ Non-Prescription: _____

RISK FACTORS

- Do you smoke or use tobacco? ☐Yes ☐No Amount per day: _____ # of years: _____ **IF NO, was there any** previous use? _____
  - ↳ If so, have you ever tried to quit? ☐Yes ☐No Would you consider (or reconsider) smoking cessation? ☐Yes ☐No
- Do you drink any alcohol? ☐Yes ☐No If so, how much per day? _____
- Would you consider yourself stressed? ☐Yes ☐No Level of stress in your life *(circle one)*: Low Medium High
- Do you have any history of any type of substance abuse? (alcoholism; recreational drugs) ☐Yes ☐No _____

MEDICAL HISTORY

Please check any of the following you may have had. Check "Family" box if other family members have been affected.

☐ Heart Valve Prosthesis
☐ Joint Replacement Surgery
☐ Organ Transplant
☐ Hepatitis (A B C) or Jaundice
☐ Liver Disorder
☐ Anemia / Sickle Cell Disease
☐ Blood Disorder / Hemophilia
☐ Frequent Mouth Sores
☐ Severe Headaches
☐ Fainting or Dizzy Spells
☐ Epilepsy / Seizures
☐ Anxiety / Panic Disorder
☐ Chemical Dependency
☐ Clinical Depression
☐ Psychiatric Care or Meds

☐ Diabetes (1) (2) ☐ Family
☐ Heart Disease ☐ Family
☐ Stroke ☐ Family
☐ Heart Attack ☐ Family
☐ High / Low Blood Pressure
☐ Angina ☐ Pacemaker
☐ Congestive Heart Failure
☐ High Cholesterol
☐ Aterio-/Athero-sclerosis
☐ Osteoporosis / Osteopenia
☐ Cortisone Therapy
☐ Parkinson's Disease
☐ Hearing Disorder / Hearing Aid
☐ Glaucoma / Impaired eyesight
☐ Do you wear contacts?

☐ Heart Murmur
☐ Rheumatic Fever
☐ Mitral Valve Prolapse
☐ Congenital Heart Lesions
☐ History of Cancer
☐ Radiation Treatment
☐ Chemotherapy
☐ Blood Transfusion
☐ Tuberculosis (TB)
☐ Persistent Cough
☐ Emphysema ☐ Asthma
☐ Sinus Problems ☐ Hay Fever
☐ Thyroid Disease ☐ M.S.
☐ Ulcers ☐ G.I. Disturbance
☐ Arthritis ☐ Rheumatism

Drug Allergy/Adverse Reaction

☐ Aspirin ☐ Anesthetic
☐ Penicillin ☐ Erythromycin
☐ Sulfa ☐ Tetracycline
☐ Codeine ☐ Barbiturates
☐ Latex ☐ Tranquilizers
☐ Iodine ☐ Epinephrine
☐ Other _____

Women: Are you going or have you been through Menopause? _____
Taking **HRT**? ☐Yes ☐No
Are you nursing? ☐Yes ☐No
Are you pregnant? ☐Yes ☐No
↳ Due Date: _____

⇨ Have you ever taken medication containing **bisphosphonate**, such as Fosamax, Actonel, Boniva, I-V Zometa or Aredia?
↳ ☐ Yes ☐ No If so, how long have you been taking the medication? _____

- Has your physician ever advised you to **pre-medicate with antibiotics** prior to having dental treatment? ☐Yes ☐No
- Have you ever had **excessive bleeding** that required special treatment? ☐ Yes ☐ No _____
- Have you been diagnosed as having any **immunodeficiency**? ☐ Yes ☐ No HIV, ARC or AIDS? ☐Yes ☐No
- Are you required, due to your health, to restrict your work or activity in any way? ☐ Yes ☐ No _____

⇨ Is there any condition or problem, listed or not, needing further clarification or that you feel we should know about you? ☐Yes ☐No
If you checked **YES** to any of the above, please explain: _____

Anything else you feel is important for us to know in order to care for you in *the best way possible* - (Bad dental experience as a child, etc.) _____

I certify the information above is correct to the best of my knowledge: X _____ _____
SIGNATURE of PATIENT, or PATIENT'S LEGAL GUARDIAN DATE